Covered Services and Limitations (Baby Care)

Last Updated: 06/03/2022

Table of Contents

Covered Services and Limitations (Baby Care)

Updated: 5/2/2017

The BabyCare program includes the following components:

- Behavioral health screenings by a physician, physician assistant or nurse practitioner as defined in Chapter II of this manual;
- Case management for high risk pregnant women and their infants up to two years of age, completed by a case manager who is licensed either as a registered nurse or qualified social worker (MSW/BSW) as defined in Chapter II of this manual; and
- Expanded prenatal services for pregnant women including individual education classes (including tobacco dependence education), nutrition services, homemaker services and substance use disorder services (SUD) by a DMAS approved provider as detailed in Chapter II of this manual.

BabyCare services described in this chapter are covered under the Virginia Medical Assistance Program. Forms referenced in this chapter may be found under the Maternal and Child Health / BabyCare section on the DMAS website at http://dmas.virginia.gov/Content_pgs/mch-home-aspx, Virginia Medicaid web portal, or Chapter IV of this manual under attachments.

Eligibility (Baby Care)

Behavioral health screenings and BabyCare case management services are available for pregnant women and infants who are enrolled in Fee-for-Service (FFS) Virginia Medicaid, Family Access to Medical Insurance Security (FAMIS), FAMIS Plus or FAMIS MOMS programs. Expanded prenatal services are available to pregnant members in FFS, FAMIS, FAMIS Plus or FAMIS MOMS programs. The covered services available to

enrollees in a MCO are described below. Pregnant women are eligible for BabyCare services during pregnancy and up to the end of the month following their 60th day post-partum. Infants are eligible for BabyCare services up to their second birthday.

To be eligible for BabyCare services, pregnant women or infants up to age two must be at risk for poor birth/health outcomes. Specific requirements are detailed in this chapter.

Managed Care Organizations (MCOs)

MCOs participating with the Virginia Medical Assistance Program have their own high risk maternity and infant programs including case management and expanded prenatal services (services comparable to those identified in 12VAC30-50-410 and 12VAC30-50- 510). Each MCO has established authorization and approval requirements for these programs. In addition, in order to provide and be reimbursed for services to a managed care member, providers must have a contract with the MCO. Providers should contact the appropriate MCO about the requirements of their maternity and infant program. A list of the MCO high risk maternity and infant program contact information for MCO members can be found as an attachment at the end of Chapter IV under Business Rules.

Substance use disorder services (SUD) for pregnant and postpartum women are described in the DMAS Community Mental Health Rehabilitative Services Manual and are not included in MCO contracts. Members who are pregnant may access substance abuse treatment through any approved DMAS-enrolled SATS provider. Also, the MCO may refer a member to these services. It is the responsibility of the provider of these services to coordinate service delivery and the member's needs with the MCO.

Eligibility / Claim Status / Service Authorization

Virginia Medicaid Web Portal

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the State Healthcare Web Portal Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

Behavioral Health Screening Tool

DMAS reimburses for administration and interpretation of the Behavioral Health Risks Screening Tool {DMAS 16-P (Provider) through the BabyCare program. This screening tool replaces the BabyCare Maternity Risk Screen (DMAS 16) and the BabyCare Infant Risk Screen (DMAS 17). The purpose for this screening is to identify and assist pregnant women as well as new mothers who may be at risk for mental health, substance use or intimate partner violence as well as infants who may be at risk for developmental issues secondary to their family situation and mother's risks. Early identification and referral for intervention of these risks are paramount in helping improve the outcomes of pregnancy as well as health/well-being of the infant. BabyCare reimburses for administration of this instrument for pregnant/postpartum women and infants up to two years of age who are enrolled in a fee-for-service using Current Procedural Terminology (CPT) codes. 96160 and/or 96161 on or after January 1, 2017. The new procedure codes are as follows:

96160 – Administration of patient-focused maternal health risk assessment instrument (e.g. health hazard appraisal) with scoring and documentation per standardized instrument, and/or;

96161- Administration of care-giver focused infant health risk assessment instrument (e.g. depression inventory) for the benefit of the patient, with scoring and documentation per standardized instrument.

Pregnant and postpartum women are at greater risk to experience depression, substance use and/or be victims of violence than women who are not pregnant and often these risks occur together. Research also shows that many times after the six week postpartum visit, the provider who has the most regular contact with new mothers is the pediatric provider. Thus, in order to identify women who may be experiencing any of these issues, DMAS has collaborated with the Virginia Department of Health (VDH), Department of Behavioral Health and Developmental Services (DBHDS) and private stakeholders to increase the use of assessments of health and behavioral risks for pregnant/postpartum women and mothers of infants up to age two, using a standardized universal tool to screen for depression, substance use and/or violence. This Behavioral Health Risks Screening Tool is located online under the Maternal and Child Health Services/ BabyCare section located: http://www.dmas.virginia.gov/Content_pgs/mch-home.aspx. DMAS has identified this instrument due

to the ease of use and the universality to detect emotional problems, alcohol, tobacco and other drug use, as well as violence. This tool is meant for a brief screening, not to assess the severity of the risks. The practitioner will determine the need for further review, referral and/or intervention as necessary.

Screening Pregnant and Postpartum Women for Substance Use

Screening During Pregnancy

Screening and brief intervention for substance use may be sufficient in helping a woman interrupt her use of alcohol or drugs during pregnancy. Other women may require additional assessments, referrals and treatment services. . The use of alcohol or drugs during pregnancy will affect the health and well-being of the mother and the newborn. Interrupting a woman's substance use and providing comprehensive services for both the mother and child during pregnancy can significantly improve birth outcomes as well as the child's later development. The Behavioral Health Risks Screening Tool uses the Institute for Health and Recovery's Integrated 5P's Screening Tool questions to detect substance use. Further screening, assessment and intervention may be required.

The provider may seek reimbursement for administering the Behavioral Health Risks Screening Tool through the most appropriate DMAS program (Community Mental Health and Rehabilitation Services or BabyCare) depending on the provider qualifications and services provided. The DMAS Community Mental Health and Rehabilitation Services program reimburses for substance use screenings and brief intervention using a DMAS approved screening tool. There are specific requirements for providers to receive reimbursement through this program. Please refer to the DMAS Community Mental Health Rehabilitation Provider manual online at the Virginia web portal found at http://www.dmas.virginia.gov or https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/_ProviderManuals for more information about substance use screening reimbursement including provider requirements and approved tools.

Screening Postpartum

The National Survey of Drug Use and Health (NSDUH) reports that many women resume substance use within the first 3 months after childbirth. Most women who stop using alcohol or drugs during their pregnancy resume use within the first year after they deliver. The most dramatic increases in substance use occur within the first 3 months postpartum.

To encourage screening women postpartum and up through the infants second birthday, BabyCare has approved for pediatric providers to be reimbursed for administering the Behavioral Health Risks Screening Tool. The pediatric provider administers the tool to the mother of their infant patients (up to age two) through the BabyCare screening code (96160 (maternal) and/or 96161(infant), and bills under the infant's benefit as a risk screening for the infant.

Note: The Virginia Department of Behavioral Health and Developmental Services (DBHDS) has more information about tips and resources for screening pregnant/postpartum women http://www.dbhds.virginia.gov/individuals-and-families/substance-abuse/pregnantwomen-families

Screening Pregnant and Postpartum Women for Intimate Partner Violence

Pregnant women should be screened at various times throughout pregnancy and postpartum for intimate partner violence. Screening should occur periodically because some women do not disclose abuse the first time they are asked and abuse may begin later in pregnancy or postpartum. The Behavioral Health Risks Screening Tool has questions which help detect if she is experiencing violence.

Screening Pregnant Women for Perinatal and Postpartum Depression (PPD)

Perinatal and postpartum depression (PPD) is a serious illness that develops during pregnancy or within one year of the pregnancy ending. PPD is a condition that affects 8% to 20% of women after delivery, especially during the first four weeks and can occur anytime during the child's first year. Studies have shown that untreated maternal depression can have a negative effect on an infant's cognitive, neurologic, and motor skill development. During pregnancy, depression can lead to preeclampsia, preterm delivery, and low birth weight. The Behavioral Health Risks Screening Tool uses the 3-Question Edinburgh Postnatal Depression Scale which can detect perinatal and postpartum depression.

Screening Mothers of Infants Up to Age Two

BabyCare will reimburse pediatric providers for administering the Behavioral Health Risks Screening Tool to mothers of infants up to age two, under the infant's medical benefit for FFS Medicaid, FAMIS or FAMIS Plus. The purpose is to identify mothers of infants who may be experiencing depression, substance abuse or intimate personal violence and thus increasing the risk that the child will have developmental issues as a result. Providers must meet qualifications as listed in Chapter II of this manual to be reimbursed through BabyCare.

Infants identified as having possible developmental delay should be referred to the Infant and Toddler Connection as well as the infant's primary care provider. This supports the role of the medical home in coordinating follow up and allows the primary care provider the opportunity to assist the parent(s) in taking steps to promote optimal development. Instructions about how to refer children to the Infant and & Toddler Connection may be found online at: http://www.infantva.org.

Referral and Follow Up for Positive Screen

Providers should discuss the need for further assessment, referral and treatment options with women who screen positive or if the provider has concerns. Options for referral and treatment services are based on the resources available in the individual's community. Providers may initiate a referral with the BabyCare case manager for assistance with coordinating available resources and providing support. Other resource options include but are not limited to the following:

- Virginia 2-1-1 (www.211virginia.org);
- Local Community Services Boards;
- Medical Treatment Facilities;
- Primary Care Providers; and
- Managed Care Organizations.

Service Requirements and Limits for Screenings (96160 and/or 96161)

There is a limit of four units per pregnant member/per provider and four units per infant member/per provider that may be billed within a year. The provider would bill one unit of 96160 and/or 96161 for the administration and brief intervention of the *Behavioral Health Risks Screening Tool.*

Service Limits ***(per provider)***	**CPT Code: 96160 and/or 96161**
Maternal	96160 4 per pregnancy (DMAS recommends one per trimester and one postpartum.)
Infant	96161 4 per year

Universal Referral Form

DMAS is a member of Virginia's Home Visiting Consortium, a collaborative effort of the early childhood home visiting programs, which serves families of children from pregnancy through age five. The Consortium is part of Virginia's Plan for Smart Beginnings (www.smartbeginnings.org). To help increase the quality and effectiveness of home visiting services, the Consortium has created a Universal Referral Form to use as a template among all home visiting programs. The Universal Referral Form may act as a referral mechanism for BabyCare services, Part C and other services that are provided in the member's home. This is used only as a referral mechanism and is not a DMAS reimbursable service. The form may be located at Home Visiting Consortium website at www.homevisitingva.com.

BabyCare Case Management Services

Case management is a service to improve coordination of care, reduce barriers, and link members with appropriate services to ensure comprehensive, continuous health care. The specific activities allowed under case management are detailed in this section.

Service Authorization for BabyCare Case Management

A maternity care coordinator or BabyCare case manager is either a Registered Nurse or Social Worker employed by a qualified service provider to provide care coordination services to eligible individuals. The RN must be licensed in Virginia and should have a minimum of one year of experience in community health nursing and experience in working with pregnant women. The Social Worker (MSW/BSW) must have a minimum of one year of experience in health and human services, and have experience in working with pregnant women and their families.

DMAS requires that the BabyCare case manager complete the initial assessment and determine that the individual may benefit from ongoing BabyCare case management services. Note: DMAS requires use of the appropriate assessment form for the pregnant woman or infant (DMAS–50 Maternal (M)

or DMAS-50 Infant (I)). The case management provider must submit a copy of the appropriate form to the fax number or email address listed below this section. The individual/individual's primary caregiver must agree to be open for BabyCare case management services in order for services to be authorized. The individual must agree to participate in the BabyCare case management program and document participation by completing a DMAS form titled "Letter of Agreement" (DMAS 55 or equivalent). The Letter of Agreement form is kept in the medical record for documentation purposes. DMAS does not require the BabyCare provider to submit the completed Letter of Agreement for authorization of BabyCare case management services but it must be available for reference if DMAS requests the document.

BabyCare case management service authorization requests must be submitted within 30 calendar days of completion by the BabyCare case manager to:

BabyCare at DMAS
Fax: 804-452-5451
*Email: BabyCare@dmas.virginia.gov
**Personal health information (PHI) can only be shared if using secure email. Please send a request to the email address above for secure email access prior to sending any PHI via email.*

Virginia Medicaid Management and Information System (MMIS) generate service authorization notifications and mails these notifications to the contact person identified on the Provider Enrollment Agreement as the contact for the BabyCare provider. If the BabyCare case management service authorization request is denied, the notification letter sent to the BabyCare provider will include information on appeals rights for the provider and the individual. BabyCare case management service authorization requests that are approved will include a written notification letter along with the BabyCare case management service authorization number and the number must be included when submitting the claim for payment of BabyCare case management services. This service authorization number must be included in Locater 23 of the CMS-1500 claim form. Claims submitted without a service authorization number will be denied.

BabyCare case management services may not duplicate any other covered service provided under the Medicaid or FAMIS State Plans or other Medical Assistance programs. (For example: The BabyCare provider must not submit a BabyCare case management service authorization request for an individual that is residing in a specialized care nursing facility.)

If the BabyCare case manager is involved in the direct provision of medical or prenatal care services, the documentation must clearly differentiate the case management services from other service provisions.

Assessment

BabyCare case management services are determined by evaluating the high risk needs identified on the assessment form (DMAS-50 Maternal (M) or DMAS-50 Infant (I)). The high risk needs can be in any or all of the elements identified in the psychosocial, medical or nutritional areas. The case manager ensures that services are arranged and continuity of care is provided in reference to services delivered, education provided and the service plan followed.

During the initial face-to-face meeting, the case manager completes a comprehensive assessment to determine the need for any medical, educational, social, or other services. DMAS requires use of the appropriate assessment form (DMAS-50 Maternal (M) or DMAS-50 Infant (I)). The assessment must be identifiable and legible. Documentation for case management services must include identification of the individual on each entry by full name and Medicaid/FAMIS identification number. Case manager documentation must also include signatures and complete dates for all documentation or entries and must include at a minimum the first initial and last name and credentials. The assessment includes but is not limited to the following:

- Taking the member's history and
- Identifying the needs of the member.

The case manager may utilize other sources, if necessary, to help complete the assessment, such as gathering information from family members, medical providers, social workers, and educators to develop a complete assessment.

Please note that the comprehensive assessments do not include performing medical or psychiatric screenings (such as the Edinburgh Postnatal Depression Scale or Ages and Stages Questionnaire Developmental Screen) but do include referrals for these screenings and time spent in preparing the referral.

BabyCare business rules can be found as an attachment at the end of Chapter IV and they provide guidance for BabyCare providers in completing the assessment for BabyCare case management service authorization requests (DMAS – 50 (M) or (I) forms) for obtaining the BabyCare case management service authorization covered service authorization number. DMAS provides authorization for BabyCare case management services for Virginia Medicaid FFS only.

Providers should adhere to the following process for FFS BabyCare case management service authorization requests submitted to DMAS using the BabyCare Fax number 804- 452-5451:

Eligibility Check:

- BabyCare providers must check eligibility prior to submitting the request to DMAS for authorization.
- It is the BabyCare provider's responsibility to verify eligibility to determine what program the individual is enrolled either FFS or MCO.
- Individuals often transition to a Virginia Medicaid MCO after enrollment for a brief period of time in FFS. For those individuals enrolled in a MCO, the BabyCare provider must have a contract with that MCO to receive authorization for covered services from the MCO.
- For those individuals enrolled in Medicaid FFS, the BabyCare provider submits the BabyCare case management service authorization request for covered services to DMAS.

Use Correct Forms:

- BabyCare providers must use the revised BabyCare case management service authorization request forms DMAS-50 Maternal (M) or DMAS-50 Infant (I).
- The forms can be found on the Virginia Medicaid web portal at www.dmas.virginia.gov or the BabyCare web page www.dmas.virginia.gov/Content_pgs/mch-home.aspx.

- The BabyCare case management service authorization requests forms must be fully completed. The form must include at a minimum: individual's name, Medicaid number, Agency name, Agency NPI number, for the pregnant woman the estimated date of delivery (EDD) or for the infant the date of birth (DOB), case management assessment date, case manager name, title and date assessment completed.

Submitting Forms:

- The BabyCare provider must submit the BabyCare case management service authorization request assessment form fully completed to DMAS for processing using the following Fax number (804-452-5451).
- BabyCare providers must submit BabyCare service authorization requests timelywithin 30 calendar days from the date the face-to-face assessment was completed and documented as the BabyCare case management date.
- There are exceptions to the 30 calendar day's timely filing and those exceptions are for those individuals that have retroactive eligibility. If the BabyCare provider has an individual that falls into this category, the provider must inform DMAS of the retroactive eligibility request prior to submitting the BabyCare case management service authorization request to DMAS for authorization. The 30 calendar day timely filing may be waived in these circumstances.

Access Authorization:

- The BabyCare provider can access BabyCare case management service authorization approvals to receive reimbursement for covered services.
- DMAS enters the BabyCare case management service authorization data into MMIS and a written notification is generated by the computer system and sent to the contact person identified in the Provider Enrollment Agreement to receive mail for the provider.
- The notification letter provides the authorization for BabyCare case management services along with the service authorization number. The BabyCare provider can obtain the service authorization number from the Virginia Medicaid web portal www.dmas.virginia.gov or by calling Medicall.at 800-884-9730 or 800-772- 9996.

How to use the Medicall system:

Call Medicall and follow the prompts:

- Once dialed in, enter the provider's National Provider Identifier (NPI);
- Select prompt #4 for service authorization status;
- Enter the member's 12 digit Medicaid number;
- Enter the date that the member was assessed by the provider and identified as the BabyCare case management open date;
- Select pound (#) (skip end date request – do not enter date);
- Select star (*) (do not know service authorization number).

Submitting Claims:

- The BabyCare provider obtains the BabyCare case management service authorization number and enters the service authorization number on the claim form along with the BabyCare

procedure code G9002.
- The BabyCare provider submits the claim including service authorization number and procedure code for reimbursement for covered services.

Authorization Period:

- BabyCare case management service will only be authorized for a period up to the date prior to managed care enrollment, if applicable
    - Example:
        - Case management requested for Mom on October 5,
        - However, Mom will transition to managed care on November 1,
        - FFS authorization period will end October 31st .
- If a managed care enrollment date is not present in the MMIS system at the time of the request, BabyCare case management will be authorized for a period not to exceed 60 days or until enrollment in a managed care health plan, whichever occurs first.
- If the member is enrolled in an MCO during the requested date of service, the service authorization requests will be returned to the provider because the member is not eligible for FFS BabyCare case management services.
- If the member meets the criteria to be excluded from managed care enrollment, the request will be authorized as follows:
    - Pregnant women are eligible for BabyCare during pregnancy and up to the end of the month following their 60th day post -partum,
    - Infants are eligible for BabyCare case management up to their second birthday.

Timely Requests:

DMAS BabyCare service authorization request for case management services must be submitted to DMAS within 30 calendar days from the date the face-to-face assessment was completed and documented on the assessment form as the case management open date (DMAS-50 M or I).

The BabyCare case management service authorization request form should include the provider requested begin date and DMAS will authorize the begin date as requested if eligible.

DMAS will not issue a service authorization number for BabyCare case management if:

1. The face-to-face assessment and service plan is not completed for the pregnant mom or the infant on the DMAS BabyCare service authorization request forms.
2. The case management open date is greater than 30 days from the date the form was submitted to DMAS (except for retrospective reviews).

Change in Eligibility:

For pregnant woman who receive a BabyCare case management service authorization under FFS, then moves to an MCO and returns to FFS in the same prenatal period, the provider shall submit the DMAS–50 Maternal (M) form and check the box for “Re-issue for same prenatal period.” DMAS shall, upon verification, reactivate the previous authorization number.

If the member loses Medicaid eligibility, including managed care eligibility, for a period of two (2)

months or more, a new face-to-face assessment shall be required prior to submission of a new service authorization request. All timely submission requirements shall apply.

Service Plan

The case manager will develop a Service Plan based on the completed assessment. The case manager may utilize the DMAS 52 or equivalent. The Service Plan must include the following:

- Specific goals and actions to address the medical, psychosocial, educational, and other services needed by the eligible individual;
- Include activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual and a plan for follow-up.

Coordination and Referral

The case manager assists the individual in arranging appropriate services and ensuring continuity of care. The case manager helps the individual obtain needed services, including those medical, psychosocial, and educational services that address the needs and goals identified in the Service Plan. These services may include, but are not limited to, coordination and referral to the following: primary medical care, Early Intervention Services/Part C, Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Early Periodic Screening Diagnosis and Treatment (EPSDT) services, expanded prenatal services, the State Tobacco Quit Line, DMAS Managed Care Organizations (MCOs) and family planning services.

Note: The case manager should discuss with the pregnant woman or caregiver of the infant the available services through Part C. If the infant appears to not be developing as expected, or has a medical condition that can delay normal development, the case manager should work with the family to initiate a referral for evaluation and assessment through Part C. The case manager may assist the family in contacting the Infant & Toddler Connection for the city or county in which the family resides via the state toll free number: 1-800-234-1448, or through the Infant & Toddler Connection website at www.infantva.org. The case manager may work with the Part C Service Coordinator to help facilitate services as necessary.

Time spent making appointments for an individual is a covered case management activity. However, accompanying or transporting individuals to appointments is not covered under FFS BabyCare Case Management. BabyCare case management referrals and related activities may include scheduling appointments, assisting the individual in completing necessary forms, coordinating services and planning treatment with other agencies and providers, and collateral contacts with significant others to promote implementation of the service plan.

Monitoring and Follow-up

The case manager assesses ongoing progress and ensures services are delivered. The case manager maintains contact with other service providers to ensure the individual keeps appointments and the individual understands and has the ability to comply with the Service Plan and any other

requirements of the service providers.

Activities may include contacts with the individual, the individual's caregiver, service providers, and/or family members as often as necessary to ensure that the Service Plan is effectively implemented and to determine if:

- Services are being furnished in accordance with the individual's Service Plan and includes activities and contacts that are necessary to ensure implementation and continued appropriateness of the service care plan;
- The plan and follow-up documented in the Service Plan are adequate to meet the member's identified needs/problems including collateral contacts, site visits and home visits; and
- There have been changes to the needs or status of the member and Service Plan requires updating.

Monitoring includes making necessary adjustments in the Service Plan and service arrangements with providers to ensure that the Service Plan adequately addresses the needs of the individual. BabyCare case management monitoring and follow-up activities includes at least one annual monitoring to ensure that:

- Services are being furnished in accordance to the service care plan;
- Services in the care plan are adequate;
- Service care plan is updated as needed.

BabyCare case management monitoring and follow-up includes the BabyCare provider monitoring and following up on the individual's needs based on the BabyCare providers professional judgement.

Education and Counseling

Education and counseling is a covered case management activity when the purpose is to guide the individual and develop a supportive relationship that promotes achieving goals in the Service Plan. Counseling, in this context, is not psychological counseling, examination, or therapy. A case management activity is defined as problem-solving activities designed to promote community adjustment and to enhance an individual's functional capacity in the community.

Allowed educational activities include discussions describing the benefits of activities listed in the Service Plan to individuals. Educational activities must be individualized. Educational activities do not include group activities that provide general information. For example, group sessions on stress management, the nature of serious mental illness, or family coping skills are not covered BabyCare case management activities.

DMAS approved education providers include individuals employed by the Virginia Department of Health, Federally Qualified Health Centers (FQHCs) or Rural Health Clinics who are approved to provide health education in the clinic setting. BabyCare providers should maintain a copy of the employee's approved certification/training in the personnel file at the agency.

Individuals who have certification from programs other than the provider types listed above may forward their course content, a copy of the certificate and the BabyCare provider enrollment application to DMAS at the following address to be reviewed for approval:

DMAS

Attention: BabyCare, Request for Member Education Certification Approval

Division of Health Care Services

600 East Broad Street

Richmond, Virginia 23219

The BabyCare individual education instructor must complete a formalized course given by a recognized accredited health care organization or education related agency which may be community or hospital based. The BabyCare individual education instructor training must be a formal course of study based on an established written curriculum. The individual education instructor training must include principles of teaching, adult learning and group education as well as content specific to the type of certification (e.g., preparation for childbirth, preparation for parenting, tobacco dependence education), and mechanisms for practice teaching and/or observed teaching practicum should be included.

Service Units and Service Limitations

Code	Description	Unit	Limits
G9001	Case management assessment and development of service plan	per assessment and service plan - jointly	2 per provider per year
G9002	Case management	per day	Requires service authorization
S0215	Travel / mileage	per mile	Requires paid case management for same time period

Note: Billing for the service can only begin with the first face-to-face contact and can be submitted only for months in which at least one direct or collateral contact, activity or communication occurs and is documented. (Collateral contact is contact with the individual, primary care provider and/or the individual's significant others to promote implementation of services.) The level of involvement will vary among individuals due to the level of need, identified risks, availability of providers/services within the area, the support available to the individual and the individual's ability to follow the Service Plan.

There must be at least one documented contact, activity or communication as designated above, and relevant to the Service Plan, during any calendar month for which BabyCare case management services are billed. Written plan development, review, other written work is not considered a billable case management activity.

In the event that the case manager cannot complete a contact during a month after case management services have been authorized, an extension of one additional month will be granted to allow the case manager time to re-connect with the individual to resume services. The case manager must document the reason the contact with the individual did not occur within the given month as well as documentation of any contacts (attempted and/or successful). If the case manager is not able

to complete a telephone, collateral or face-to-face contact during the one month extension, the individual's case must be closed. The provider must send a letter stating that the individual's- case is being closed, to the member and the member's primary care provider or referral source.

Initial Contact Requirements for Case Management

Upon referral or indication that a member may benefit from case management, the case manager must initiate contact to the member or member's caregiver to schedule a face-toface meeting. A telephone call or collateral contact must be made, at a minimum, within 15 calendar days from the date the referral was received. A collateral contact is defined as contact with the member, primary care provider and/or the member's significant others to promote implementation of services. The provider should maintain privacy requirements as set forth by Health Insurance Portability and Accountability Act (HIPAA)

The initial face-to-face contact must occur within 30 calendar days from the date the referral was received. If the case manager cannot make the face-to-face contact within 30 calendar days from the date the referral was received, an extension of 30 calendar days will be granted to allow the case manager to continue efforts to engage member in services. If the case manager is not able to complete the face-to-face contact during the 30 calendar day extension period, the case manager must close the case and notify the referring provider as applicable and the member's primary care provider.

Note: DMAS will only authorize case management at the time the face-to-face assessment and development of service plan is complete and the individual/individual's representative has agreed to be open for BabyCare case management services. If the face-to-face assessment and service plan is not completed, DMAS will not issue a service authorization number to use to bill for BabyCare case management services.

Home Visits

Face-to-face visits may take place in various settings such as the home, an office, and school, place of business, doctor's office or clinic. DMAS requires the case manager complete a minimum of one home visit to assess the member's home environment. DMAS requires that the case manager conduct a home visit with the member within 30 days from the date of referral to the program in order to complete an initial assessment of the home environment. If the case manager is unable to complete a home visit, there must be clear documentation why the home visit did not occur (i.e. the member or other member of the family refuses to allow the case manager in the home). The BabyCare case management service authorization request is only reimbursable if the DMAS-50 Maternal or Infant high risk assessment form is completed in full.

Closing a Case

An individual is closed to BabyCare case management services if the BabyCare provider is unable to establish a successful contact during a month and an extension of one month was granted. If the BabyCare provider is unable to establish a successful contact afer 60 days the BabyCare provider closes the individual's case.

Case management is covered for the maternal member to the end of the month following the sixtieth

(60th) day post-partum and the infant up to their second birthday. If an individual is enrolled in an MCO, BabyCare case management is closed in FFS because the MCOs have high risk pregnant women and their infant programs. The case must be closed if one of the following occurs:

- The member's goals are met and the member is no longer in need of services;
- The maternal member reaches the end of the month following their 60th day postpartum;
- The child member reaches age two;
- The case manager is not able to establish contact with member for 60 consecutive days;
- The maternal member or infant's caregiver request to discontinue services;
- The individual is enrolled in an MCO;
- The individual no longer meets criteria;
- The individual moves out of the service area.

Prior to closing the individual to services, the BabyCare provider case manager needs to ensure a smooth discharge or transition by assisting the individual in locating community services which may be available to the individual and notify the other individual's providers , as appropriate, that services are being discontinued. The Service Plan must be updated and the termination reason must be included in the medical record.

If a member who was closed to case management services becomes eligible again, the provider must follow the guidelines for new enrollments. Note: DMAS no longer requires the BabyCare provider to send notification of the closure/transfer from FFS to an MCO.

Transfers to Managed Care Organizations (MCOs)

Members will often transfer between Fee-for-Service (FFS) and an MCO. Note: DMAS does not require the provider to send notification of the transfer from FFS to an MCO. Providers should contact the appropriate MCO about the requirements of the specific MCO's high risk maternity and infant program and request for continuation of service authorization.

It is the responsibility of the BabyCare provider to verify the individual's eligibility for BabyCare case management service authorization services to ensure they have the appropriate authorizations, approvals, and meet contract requirements in order to bill for services (either FFS or the MCO).

Service Requirements for Expanded Prenatal Services

The BabyCare program offers the following expanded prenatal services:

- Individual Patient Education Classes
- Nutrition Services
- Blood Glucose Meters
- Homemaker Services
- Substance Use Disorder Services

Referrals for expanded prenatal services may occur at any time during the pregnancy. In most instances, a pregnant woman who requires expanded prenatal services will also have been referred for BabyCare case management. In cases where there is more than one provider able to provide

expanded prenatal services to the individual, the individual must be given a choice of providers and this choice must be documented in the individual's record.

DMAS no longer requires a primary care referral for eligible individual patient education classes, nutritional services or homemaker services. DMAS recommends that the individual's primary care provider is made aware of any referral for these services.

BabyCare providers of expanded prenatal services must be enrolled as a provider with DMAS and meet provider requirements as detailed in Chapter II of this manual to receive reimbursement for these services.

Individual Patient Education (S9442 and S9446)

Individual Patient Education includes six (6) classes of education for pregnant women in a planned, organized teaching environment including but not limited to topics such as body changes, danger signals, breastfeeding, signs and symptoms of preterm labor, alcohol/tobacco/substance use and cessation, labor and delivery information, courses such as planned parenthood, safety (such as Sudden Infant Death Syndrome {SIDS}), lead safety, safe sleeping (back-to-sleep), Lamaze, parenting, child safety and child rearing. There is a limit of six classes under Childbirth Education (S9442) and six classes under Parenting Education (S9446) per member (see list of classes in Appendix B in this manual).

The individual patient educator is responsible for offering group classes to the individual and documenting the individual's attendance and completion of the classes. In addition, the patient educator must notify the primary care provider and/or case manager of the dates on which the individual attended classes and any final recommendations for followup or additional services needed.

Tobacco Dependence Education (S9446)

Tobacco dependence education is a priority topic for individual education. All education sessions may target tobacco dependence education. Research shows that tobacco use nearly doubles the rate of a woman having a low birthweight infant. Tobacco use also increases the risk of preterm delivery (before 37 weeks of gestation). Premature and low birthweight infants are at greater risk of serious health problems after birth, chronic lifelong disabilities and even death.

Research shows that if a woman stops smoking by 16 weeks gestation, she is at no more risk to have a low-birthweight infant than a woman who never smoked. Women who quit smoking by 30-36 weeks gestation have near normal birthweight infants.

The single most important step in addressing tobacco use and dependence is screening for tobacco use. The provider must first ask the member about their tobacco use and assess their willingness to quit. The provider can then determine the most appropriate intervention, either by assisting the member in quitting (the "5As") or by providing a motivational intervention (the "5Rs") (for more information on the 5As or 5Rs, see below).

Education and counseling by individual healthcare providers has been proven effective among certain groups, especially pregnant women. DMAS covers Tobacco Dependence Education through

BabyCare Individual Education for pregnant members.

The purpose of DMAS covered tobacco dependence education is to offer education about the health benefits of quitting tobacco use and refer the individual to a provider for tobacco dependence treatment as well as the Virginia Quit Line for further intervention.

There is a limit of 6 sessions per member per provider (S9446). This may be combined with the nicotine replacement products which are covered through the pharmacy benefit for FFS members.

Tobacco Dependence Treatment Resources

Counseling services include evidenced-based screening and brief intervention services such as the 5As as well as the 5Rs. The 5As are intended for smokers who are willing to make a quit attempt. The 5Rs are directed for smokers who are unwilling to make a quit attempt at this time. For more information about 5As, visit Department of Behavioral Health and Developmental Services (DBHDS) website for screening tools and guidance for pregnant women or the Virginia Department of Health website. For more information about the 5Rs, please visit the United States Department of Health and Human Services website or the Virginia Department of Health website.

Providers should also refer members to the Quit Now Virginia program http://166.67.66.226/livewell/programs/tobacco/quitnow.html (1-800-QUIT NOW or 1-800-784-8669). Quit Now Virginia is a free service and has trained counselors to provide practical counseling via telephone, as well as support, materials, relapse prevention, follow-up and provider consults.

Providers should continue to monitor the website for DMAS to get up-to-date information of tobacco cessation coverage for pregnant members.

Nutrition Services

Nutrition Services include nutrition assessment of dietary habits, development of a nutrition care plan, nutrition counseling and counseling follow-up. This information is provided in addition to the expected basic nutrition information pregnant women receive from their medical care providers or the WIC Program http://www.vdh.virginia.gov/livewell/programs/wic/ through the Virginia Department of Health. The information must be provided by a Registered Dietitian (R. D.) or a person with a master's degree in nutrition, maternal and child health, or clinical dietetics with experience in public health, maternal and child nutrition, or clinical dietetics.

Program criteria for referral to nutrition prenatal care services includes, but is not limited to, the following: pre-pregnancy underweight/overweight, inadequate or excessive weight gain, a teenager 18 years of age or younger, poor diet, pica, an obstetrical or medical condition requiring diet modification such as multiple gestation, delayed uterine growth, diabetes, hypertension and anemia.

The provider must complete an assessment within 30 days of the referral from the primary care provider or case manager and offer any follow-up nutrition counseling indicated. DMAS will reimburse a provider for the initial nutrition assessment and up to two (2) follow-up visits.

The initial orientation and periodic follow-up should include education concerning basic nutrition

during pregnancy, appropriate weight gain during pregnancy and dietary intake. Nutrition assessment, development of a nutrition care plan, provision of nutrition counseling is provided, including appropriate referrals and linkage with WIC.

The provider must forward a copy of the nutrition assessment to the primary care provider. Upon completion of the nutrition counseling, the provider must provide the primary care provider with a report of the progress of the individual and final recommendations.

Please refer to the DMAS Durable Medical Equipment (DME) provider manual for requirements regarding nutritional counseling related to women who receive glucose monitors.

Glucose Monitors

Women with diabetes need to regularly check and control their blood glucose levels. If a woman has medical conditions caused by her diabetes, pregnancy can make these conditions worse. Miscarriage and stillbirth are more common in pregnant women with diabetes. The risks for problems of mother and baby are decreased if the woman maintains her blood glucose levels in the normal range before and during pregnancy.

DMAS will reimburse for blood glucose monitors and test strips for pregnant women suffering from diabetes for which the practitioner determines nutritional counseling alone will not be sufficient to assure a positive pregnancy outcome. As of July 1, 2010, the Maternity Risk Screen (DMAS-16) is no longer required under DME services. Please refer to the DMAS DME Provider Manual, Chapter IV – Covered Services, regarding additional requirements. The DMAS DME Provider manual is available online at http://dmasva.dmas.virginia.gov.

Note: 12VAC30-50-510 requires that women who receive a blood glucose meter covered by DMAS, must also be referred for nutrition counseling. Blood glucose meters shall be provided by Medicaid enrolled durable medical equipment providers.

Homemaker Services

Homemaker Services include those services necessary to maintain household routine for pregnant women, primarily in the third trimester, who need bed rest. Services include, but are not limited to, light housekeeping, child care, laundry, shopping, and meal preparation.

To qualify for homemaker services, the member must be referred by her primary care provider who has determined that it is medically necessary for the member to be on bed rest. The homemaker services must be rendered by Medicaid certified providers.

Duties may be performed by a companion, homemaker, nursing assistant or home health aide. A RN or Social Worker must provide supervision to the care providers.

The RN or Social Work supervisor must make an initial home assessment visit prior to the start of care and develop a written Service Plan with the member for the homemaker to follow. The supervisor is also responsible for introducing the assigned homemaker to the member and reviewing with the homemaker and the member the duties the homemaker will be performing. The homemaker may perform any household duties which follows the Service Plan and enables complete bed rest as

ordered by the individual's primary care provider. The supervisor shall make supervisory visits as often as needed to ensure both the quality and appropriateness of services.

The homemaker may not transport the individual in the homemaker's personal car or perform any skilled nursing care procedures.

The homemaker agency and the member may decide the number of hours of care that are needed per day. There is a limit of 124 hours per 31 days.

If services are medically necessary beyond 31 days, extensions may be requested from DMAS. The member's primary care provider must write a letter of medical necessity that includes the following information: the member's name and current Medicaid/FAMIS/FAMIS Plus/FAMIS MOMS ID#; a brief justification for the continued need for bed rest (e.g., placenta previa, preterm labor); and, the expected amount of time the member will need bed rest. The estimated date of delivery should be included if bed rest is required through delivery.

To obtain approval for additional hours, a copy of the medical necessity letter should be forwarded to the BabyCare Program at DMAS:

BabyCare at DMAS

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Fax: 804-452-5451

Following review of the medical necessity letter, DMAS will send a letter authorizing further reimbursement for homemaker services to the case manager or primary care provider if the member is not receiving case management services. If the member is authorized by DMAS to receive more than 31 days of homemaker services, the homemaker supervisor must make additional supervisory visits at a minimum frequency of every 30 days. The homemaker must be present during the supervisor's visit at least every other month. Flow sheets must be used by the homemaker/supervisor for documentation purposes. Each date of service must be documented and signed by the homemaker and the individual.

Substance Use Disorder Services

Please refer to the DMAS Community Mental Health Rehabilitative Services Manual for service definitions and requirements. A copy of this manual is available on the DMAS website at http://www.virginiamedicaid.dmas.virginia.gov

Related Programs for Pregnant Women and Children

The following information describes selected services that the case manager may use for service planning and referral.

Home Health Services

Home health services, while not specifically a prenatal care service, are also available when ordered by a physician for pregnant women whose medical complications require short-term, intermittent nursing care. Such services are provided by DMAS-enrolled home health agencies according to a written plan of care.

For more information, refer to the DMAS Home Health Manual. A copy of this manual is available on the DMAS website at http://www.virginiamedicaid.dmas.virginia.gov

Family Planning Services

Family planning services are covered by the Virginia Medical Assistance Program when rendered by DMAS-enrolled providers. These services include counseling, member education, examination, and treatment as prescribed by a physician for the purpose of family planning. For more information, refer to the DMAS Physician's Provider Manual. A copy of this manual is available on the DMAS website at http://www.virginiamedicaid.dmas.virginia.gov

Plan First Program

Plan First is DMAS' fee-for-service family planning services program. The purpose of this program is to cover services that help an individual prevent an unplanned pregnancy. Plan First reimburses health care providers for limited family planning services for men and women who meet the Plan First eligibility requirements.

For additional information, refer to the DMAS Plan First Manual. A copy of this manual is available on the DMAS website under 'Provider Services' at http://www.virginiamedicaid.dmas.virginia.gov. More information about Plan First Cover Virginia is also located at http://dmasva.dmas.virginia.gov/Content_atchs/mch/mchpln1_rcpnts_fcts.pdf.

Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT)

Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) are a comprehensive and preventive child health program for individuals under the age of 21. EPSDT includes periodic screening, vision, dental and hearing services. In addition, under the Social Security Act Section 1905(r)(5), States are required to provide any medically necessary health care services listed at section 1905 (a) of the Social Security Act to correct and ameliorate physical and mental conditions even if the service is not included under the state's Medicaid plan. These services are referred to as EPSDT "Specialized Services." All EPSDT "Specialized Services" must be a service that is allowed by the Centers for Medicare and Medicaid Services (CMS). The allowable treatment services are defined in the United States Code in 42 U.S.C. sec 1396d (r) (5).

- The most frequently provided EPSDT specialized services are:
- Hearing Aids
- Assistive Technology
- Personal Care
- Private Duty Nursing
- Medical Formula and Medical Nutrition Supplements

- Specialized Behavioral Rehabilitation and Residential Treatment Services
- Substance Use Residential Treatment Services (effective April 1, 2017 - see ARTS Provider Manual)

For more information on EPSDT, refer to the DMAS EPSDT Manuals available on the DMAS website at http://www.virginiamedicaid.dmas.virginia.gov.

Smiles For Children

The Smiles For Children http://www.dmas.virginia.gov/content_pgs/dnt-home.aspx program provides coverage for diagnostic, preventive, restorative/surgical procedures, as well as orthodontia services for Medicaid, FAMIS and FAMIS Plus children. The program also provides limited coverage for medically necessary oral surgery services for adults (age 21 and older) – see below. DentaQuest http://www.dentaquestgov.com/ is the single dental benefits administrator that will coordinate the delivery of all Smiles For Children dental services.

Dental Services for Pregnant Women

Dental treatment for adults, including pregnant women enrolled in Medicaid and FAMIS MOMS, is covered under certain circumstances through Virginia's dental program, ***Smiles For Children***. Adult dental services are limited to medically necessary oral surgery and associated diagnostic services, such as X-rays and surgical extractions. Preventive, restorative, endodontics, and prosthetic services e.g. cleanings, fillings, root canals and dentures are not covered for adults. Dental conditions that may qualify for reimbursement are ones compromising a patient's general health and such conditions must be documented by the dentist or medical provider. Symptoms would include pain and/or infection.

Additional information about the Smiles For Children program is available at http://www.dmas.virginia.gov/content_pgs/dnt-home.aspx.

Women, Infants and Children's Supplemental Food Program (WIC)

WIC is a supplemental food and nutrition education program that provides assistance with the purchase of nutritious foods and dietary counseling to pregnant, postpartum or breastfeeding women and children under age five with special nutrition and financial needs. Any Medicaid/FAMIS/FAMIS Plus/FAMIS MOMS-eligible individual meeting the criteria must be referred to his or her local health department for additional information and eligibility determination. Additional information can be found the Virginia Department of Health http://www.vdh.virginia.gov/ website or by contacting the Virginia Department of Health at 1-888-942-3663.

Child Care Resources

Virginia Child Care Resource and Referral Network (VACCRRN) is a community-based network of early care and education specialists whose purpose is to deliver services to families, child care professionals and communities to increase the accessibility, availability, and quality of child care in Virginia. For more information about VACCRRN, please visit http://childcareaware.org/ (ChildCare Aware of Virginia) or call 1-866-KIDS-TLC.

Head Start

Head Start is a national child development program for children from birth to age 5. Head Start provides services to promote academic, social and emotional development for income-eligible families. Head Start provides comprehensive education, health, nutrition, dental, mental health, social services and parent involvement opportunities to low-income children and their families. In Virginia, the goals of Head Start are to enhance children's physical, social, emotional and cognitive development; enable parents to be better caregivers and teachers to their children; and, help parents meet their own goals, including economic independence. More information on Head Start in Virginia can be found on the Virginia Head Start Association, Inc. website at http://www.dss.virginia.gov/family/cc/headstart.html or by calling Head Start Virginia Department of Social Services by calling 804-726-7000 or 800-552-3431 toll free, located at 801 East Main Street, Richmond, VA. 23219

Early Intervention

Part C of the Individuals with Disabilities Education Act (IDEA) is a federal grant program that assists states in operating a comprehensive statewide program of early intervention services for infants and toddlers with disabilities, ages birth through age 2 years, and their families. In Virginia, Part C services are provided through the Infant & Toddler Connection of Virginia. Infant & Toddler Connection of Virginia provides early intervention supports and services to infants and toddlers from birth through age two who are not developing as expected or who have a medical condition that can delay normal development. Early intervention supports and services focus on increasing the child's participation in family and community activities that are important to the family. In addition, supports and services focus on assisting parents and other caregivers to find ways to help the child learn during everyday activities. These supports and services are available for all eligible children and their families regardless of the family's ability to pay.

Additional information on early intervention services in Virginia can be found on the Infant & Toddler Connection of Virginia website at www.infantva.org or by contacting the Virginia Department of Behavioral Health and Developmental Services (DBHDS).

Other Home Visiting Programs

Please visit the Virginia Home Visiting Consortium at www.homevisitingva.com for more information on home visiting programs in Virginia as well as trainings available for home visitors.

Client Medical Management Program (Baby Care)

As described in Chapters I, III and VI of this manual, the State may designate certain individuals to be restricted to specific physicians and pharmacies. When this occurs, it is noted on the member's Medicaid/FAMIS ID card. A DMAS-enrolled physician who is not the designated primary provider may provide and be paid for outpatient services to these members only:

- In a medical emergency situation in which a delay in the treatment may cause death or result

in lasting injury or harm to the member;
- On written referral from the primary health care provider using the Practitioner Referral Form (DMAS-70). This also applies to covering physicians.
- For other services covered by DMAS which are excluded from the Client Medical Management Program requirements.

The primary health care provider must complete a Practitioner Referral Form (DMAS70) when making a referral to another physician or clinic. The appropriate billing instructions for these situations are covered in Chapter V. Covered outpatient services excluded from this requirement include:

- Local education agency providers;
- Renal dialysis clinic services;
- Routine vision care services (routine diagnostic exams for members of all ages and eyeglasses for members under age 21) provided to restricted members; (NOTE: Medical treatment for diseases of the eye and its appendages still requires a written referral or may be provided in a medical emergency.)
- Baby Care services;
- Personal care services (respite care or adult day health care);
- Ventilator-dependent services; and
- Prosthetic services.

These services must be coordinated with the primary health care provider whose name appears on the individual's eligibility card, but they are excluded from special billing instructions for the Client Medical Management Program. Other DMAS requirements for reimbursement, such as service authorization, still apply as indicated in each provider manual.

Claim Inquiries & Reconsideration

Inquires concerning covered benefits, specific billing procedures or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, VA 23219

A review of additional documentation may sustain the original determination or result in an approval or denial.

Telephone Numbers

1-804-786-6273 Richmond Area and out-of-state long distance

1-800-552-8627 In-state long distance (toll-free)

Fee-for-Service BabyCare Case Management Service Authorization (SA) Request Business Rules

Topic	Information
BabyCare Case Management	Case management is a service to improve coordination of care, reduce barriers, and link members with appropriate services to ensure comprehensive, continuous health care.
Regulation	12VAC30-50-410 Case Management Services for High Risk Pregnant Women and Children http://law.lis.virginia.gov/admincode/title12/agency30/chapter50/section410/
BabyCare Provider Manual	Provider Requirements, Covered Services, and Documentation Requirements https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual
Eligibility Criteria	• Pregnant women up to end of the month following the 60th day postpartum • Infants from birth up to the age of 2 years To be eligible for BabyCare services, pregnant women and infants up to age two must be at risk for poor birth/health outcomes.
SA Request Forms	BabyCare Service Authorization Requests DMAS 50-I: Infant High Risk Case Management DMAS 50-M: Maternal High Risk Case Management https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderFormsSearch
Eligibility Verification and FFS Service Authorization Numbers	Medicall: 800-884-9730 or 800-772-9996 Automated Response System (ARS) Web Portal www.virginiamedicaid.dmas.virginia.gov
BabyCare FAX	NEW FAX # 804-452-5451
MCO Contact Information for Managed Care Members	Managed Care High Risk Maternity and Infant programs information: http://dmasva.dmas.virginia.gov/Content_atchs/mc/mc-guide_p2.pdf. Aetna Better Health: • Baby Matters (1-800-279-1878) Anthem HealthKeepers Plus: • Future Moms (1-800-828-5891) INTotal Health: • Starring Baby and Me (1-855-323-5588) Kaiser Permanente: • Healthy Mom Healthy Baby (1-866-223-2347) Optima Family Care: • Partners in Pregnancy (1-866-239-0618) Virginia Premier: • Healthy Heartbeats (1-800-727-7536)
More Information	More information about BabyCare may be found at http://www.dmas.virginia.gov/Content_pgs/mch-home.aspx

BabyCare Case Management Service Authorization (SA) Requests

Business Rules Process for Virginia Medicaid Fee-for-Service (FFS) Members

1. **Enrolled Providers**

Any provider of case management services for fee-for-service members must be an enrolled provider with DMAS prior to billing for any services provided to Medicaid, FAMIS, FAMIS Plus, or FAMIS MOMS members.

BabyCare Case Management services may be provided by a

- Registered Nurse (RN) who has an unrestricted license by the Virginia Department of Health Professions, Virginia Board of Nursing with a minimum of one year of experience in community health nursing and experience in working with pregnant women; or
- Social Worker who has either a master's or bachelor's degree in social work from a school of social work accredited or approved by the Council on Social Work Education with a minimum of one year of experience in health and human services and experience in working with pregnant women and their families.

Refer to Chapter II of the BabyCare Provider Manual for provider qualification requirements.

2. Eligibility

Pregnant women are eligible for BabyCare case management during pregnancy and up to the end of the month following the 60th day post-partum. Infants are eligible for BabyCare case management from birth up to their second birthday. BabyCare case management program is for FFS members only. The Virginia Medicaid/FAMIS managed care organization have high risk maternity and infant case management programs.

The pregnant woman, or caregiver/parent of the infant, must agree to be open for case management and sign the Letter of Agreement (DMAS-55 or equivalent) that becomes part of the

medical record. The Letter of Agreement does not need to be submitted to DMAS to process the service authorization request.

Providers **must** verify Medicaid/FAMIS/FAMIS MOMS eligibility prior to completing and submitting the BabyCare case management service authorization requests to DMAS. Verification can occur through a verification vendor, the Automated Response System (ARS) Web Portal www.virginiamedicaid.dmas.virginia.gov or Medicall at 800-884- 9730 or 800-772-9996. The eligibility verification process will provide information on which program the recipient is participating (Medallion 3.0, Medicaid Fee-For-Service, or FAMIS).

Most individuals are covered under a Virginia Medicaid/FAMIS contracted managed care organization (MCO). If the member is enrolled in an MCO at the time of the request, the BabyCare case management service authorization request will be rejected and the provider must contact the appropriate MCO about the requirements of the specific MCO's maternity and infant program and for transition of care. Providers must be contracted with the MCO in order to bill for services.

Refer to Chapter IV of the BabyCare Provider Manual for information on eligibility.

3. Case Management Assessment

DMAS requires that the BabyCare case manager complete the initial assessment and forward a copy of the DMAS-50 (M) or(I) to BabyCare at DMAS (Fax: 804-452-5451 or email to BabyCare@dmas.virginia.gov**). Authorization begins only when the first face- to-face visit is completed. ** **Personal health information (PHI) can only be shared if using secure email. Please send a request to the email address above for secure email access prior to sending any PHI**

via email.

4. Timely Submissions of Service Authorization Requests

A service authorization must be obtained for FFS Medicaid/FAMIS members that are eligible for BabyCare case management services. Providers may submit BabyCare case management service authorization requests only after the completion of the face-to-face assessment, development of service plan and the member/member representative has agreed to receive BabyCare case management services.

The DMAS BabyCare Service Authorization request for case management services must be submitted to DMAS **within 30 calendar days from the date the face-to-face assessment was completed and documented on the DMAS-50 (M) or (I) as the case management open date**. Providers will need this date to obtain the service authorization numbers as detailed in Section 9 of this document.

DMAS will not issue a service authorization for BabyCare case management

a. If the face-to-face assessment and service plan is not completed for the pregnant mom or the infant on the DMAS BabyCare Service Authorization Request forms
b. If the case management open date is greater than 30 days from the date the form was submitted to DMAS (except as detailed in Section 5 of this document).

The BabyCare case management service authorization request form should include the provider requested begin date and DMAS will provide the authorized date. A system generated letter with the decision determination and approved dates in reference to the service authorization will be mailed to BabyCare providers including the procedure code as requested by the provider.

5. Exceptions to Timely Submission Requirements

Retrospective Reviews:

Medicaid assumes no financial responsibility for services rendered prior to the effective date of a member's eligibility. The effective date of Medicaid eligibility may be retroactive up to three months prior to the month in which the application was filed, if the patient was eligible during the retroactive period. Once a patient is found eligible, providers may bill Medicaid for covered services.

Retrospective review will be performed when a provider is notified of a patient's retroactive eligibility for Virginia Medicaid coverage. Providers must request a retrospective service authorization within 30 days of the member becoming retroactively enrolled in Medicaid and prior to billing for services.

6. Incomplete Service Authorization Requests

All BabyCare case management service authorization requests must be submitted to DMAS on the DMAS-50 maternal (M) or infant (I) form with all of the required information. Forms may be found under the Maternal and Child Health/BabyCare section on the DMAS website at http://dmasva.dmas.dmas.virginia.gov or at the Medicaid Portal:

https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderFormsSearch.

The DMAS-50 assessments must contain information that is identifiable and legible. The required information includes providing the correct:

- Member name
- Medicaid/FAMIS identification number
- Member date of birth for infants or expected delivery date for pregnant women
- Date assessment completed
- Provider case management begin date

- Agency name
- National Provider Identifier (NPI #)
- Check all risks identified, minimum of one to authorize case management
- Signature and title of case manager completing assessment

The BabyCare service authorization request will only be reimbursable if the DMAS-50

(M) or DMAS-50 (I) is completed in full. All incomplete service authorization requests will be pended and returned to the provider for correct information.

DMAS will return pended requests to providers via fax within three (3) business days of the original receipt of the request by DMAS. Providers will have three (3) business days from the DMAS return date to submit a completed form. If the form is not returned by the provider within this timeframe, the original request will be rejected and DMAS will process the service authorization and the case management begin date will be the date the completed form was received at DMAS.

7. Incorrect Signature Protocol

Signatures and complete dates are required for all documentation and must include, at a minimum, the first initial and last name and credentials of the provider.

The service authorization request will be pended and returned to the provider if the signature protocol is not followed.

8. Authorization Period

It is the responsibility of the provider to **verify the member's eligibility prior to submitting case management service authorization requests** as members often transfer between fee-for-service and managed care. Service authorizations requests will be rejected and returned to the provider if the member is enrolled in an MCO during the requested date of service.

DMAS will only authorize case management services through the date prior to managed care enrollment. If a managed care enrollment date is not present in the MMIS system at the time of the request, case management shall be authorized for a period not to exceed

60 days or until enrollment in a managed care health plan, whichever occurs first. If the member meets the criteria to be excluded from managed care enrollment, the request will be authorized as follows:

a. Pregnant women are eligible for BabyCare during pregnancy and up to the end of the month following their 60th day post-partum; or
b. Infants are eligible for case management up to their second birthday.

9. Service Authorization Numbers

Providers should not contact DMAS BabyCare staff requesting the authorization number or to generate a duplicate authorization number. It is the responsibility of the provider to obtain the authorization number via the DMAS web portal or call MediCall at 1-800-884-9730 or 800-772-9996. The provider will need the BabyCare case management open date to obtain the service authorization number. The case management open date is the first begin date for BabyCare case management services.

How to use Medicall:

1. Once dialed in, enter National Provider Identifier
2. Select #4 for Service Authorization status
3. Enter Member ID (12 digits)
4. Enter the BabyCare case management open date
5. Select pound # (skip end date request – do not enter date)
6. Select star * (do not know service authorization number)

The Virginia Medicaid Web Portal will not have authorization

numbers for those recipients enrolled in managed care.

Virginia Medicaid Management and Information System (MMIS) generates service authorization notifications and mails those within one (1) business day of authorization of services. If the service authorization is rejected, the notification letter will include the reason for the rejection. Requests that are approved include a service authorization number. This service authorization number must be included in Locator 23 of the CMS - 1500 claim form. Claims submitted without a service authorization number will be denied.

10. Transfers to Managed Care Organizations (MCOs)

Members will often transfer between FFS and an MCO. Providers should contact the appropriate MCO about the requirements of the specific MCOs maternity and infant program and the transition of care. It is the responsibility of the provider to verify the member's eligibility each time services are rendered to ensure they have the appropriate authorizations, approvals, and contract requirements in order to bill for services (either FFS or the MCO).

For pregnant women who receive a service authorization under FFS, then move to an MCO, and return to FFS in the same prenatal period, the provider shall submit the DMAS-50 maternal (M) and check the box for "Re-issue for same prenatal period." DMAS shall, upon verification, reactivate the previous authorization number.

11. Changes in Eligibility

If the member loses Medicaid eligibility, including managed care eligibility, for a period of two (2) months or more, a new face-to-face assessment shall be required prior to submission of a new service authorization requests. All timely submission

requirements as outlined in Section 4 of this document shall apply.